

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06301

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>50 yrs</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> TOWN STREET ADDRESS <u>Aurora Rd.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Mary</u> (Middle) <u>Dawson</u> (Last) <u>Adkins</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>28</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Nov. 26, 1861</u>	9. AGE last birthday <u>89</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Talbot, Md.</u>	
13. FATHER'S NAME <u>Mordecai N. Dawson</u>		14. MOTHER'S MAIDEN NAME <u>Deborah Cornelia Parrott</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>✓</u>		17. INFORMANT <u>Miss Edith Adkins</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Arteriosclerotic Heart Disease</u>		<u>6 months</u>
Antecedent cause(s) (b) <u>Arteriosclerosis, generalized</u>		<u>2 yrs?</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1946, to 6/28/1957, that I last saw the deceased alive on 6/28/1957, and that death occurred at 10:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>June 30, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	LOCATION (City, town, or county) <u>Easton</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>6/29/57</u>	REGISTRAR'S SIGNATURE <u>N.H. Neer</u>	24. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Adkins</u>	ADDRESS <u>Talbot, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES GOVERNMENT

OFFICE OF THE SECRETARY OF DEFENSE

MEMORANDUM FOR THE SECRETARY OF DEFENSE

Subject: [Illegible]

Reference is made to [Illegible]

It is recommended that [Illegible]

The proposed action is [Illegible]

Very truly yours,

[Illegible Signature]

[Illegible Title]

RECEIVED
JUL 9 1961
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06302

CERTIFICATE OF DEATH

Reg. Dist. No. 290

Palmer

1. PLACE OF DEATH - COUNTY <i>Eastern Talbot</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <i>Queenstown</i> COUNTY <i>Queen Anne</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Queenstown Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Easton Memorial Hospital</i>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <i>Louise</i>	(First) (Middle) (Last) <i>AEloff-</i>	4. DATE OF DEATH (Month) (Day) (Year) <i>June 8 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>9/13/97</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>N. W. at home</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Md. (Grassville)</i>
13. FATHER'S NAME <i>Mr. James B. Hess</i>		14. MOTHER'S MAIDEN NAME <i>Miss M. Taylor</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT AND ADDRESS <i>Mr. Charles Althoff</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Myocarditis

Antecedent cause(s)

(b)

Coronary Thrombosis
Arteriosclerotic Cardiovascular Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *May 24, 1957*, to *June 8, 1957*, that I last saw the deceasedalive on *June 8, 1957*, and that death occurred at *1:30 A.M.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*M. V. Palmer**M.D.**Easton, Md.**6/12/57*

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*6/9/57**M. A. Neer**Barton Bros**Centerville Md*

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1951

BUREAU V. S.

06303

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Caroline	
CITY (If outside corporate limits, write RURAL and give nearest town) EASTON		CITY (If outside corporate limits, write RURAL and give nearest town) Federalburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL		STREET ADDRESS (If rural give location) ✓	
3. NAME OF DECEASED (Type or Print) ROY (First) ARNEY (Last)		4. DATE OF DEATH (Month) 6 (Day) 28 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH about 1887
9. AGE last birthday 64 yrs.		10. If under 1 year Months 6 Days 28 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY unemployed	
11. BIRTHPLACE (State or foreign country) Caroline Co. Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John Frank Arney		14. MOTHER'S MAIDEN NAME Ella Todd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 2-25-7248	
17. INFORMANT J. J. Trappett & Son			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause Automobile accident			4 days
Antecedent cause(s) Chest injury			4 days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last Arteriosclerotic heart disease			Years
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) highway	
TIME (Month) (Day) (Year) (Hour) OF INJURY 6 24 51 09 PM		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? struck by car while riding bicycle		(CITY OR TOWN) Federalburg (COUNTY) Caroline (STATE) Md	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE Louis White, Md. D.M.E.		DATE SIGNED 6-28-51	
23. BURIAL, CREMATION, REMOVAL (Specify) Buried		DATE THEREOF 7/2/51	
NAME OF CEMETERY OR CREMATORY Still Crest		LOCATION (City, town, or county) Federalburg Md (State) Md	
DATE REC'D BY LOCAL REG. 6/29/51		24. FUNERAL DIRECTOR J. J. Trappett & Son ADDRESS Federalburg Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 6 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06304

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Exton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Exton Memorial Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Oxford</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Ezekiel</u> (First) (Middle) (Last) <u>Corkran</u>		4. DATE OF DEATH <u>June 27</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 3/1878</u>
9. AGE last birthday <u>73</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Commercial Interplan</u>	
11. BIRTHPLACE (State or foreign country) <u>Talbot Co Md</u>		12. CITIZEN OR WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Mr Charles Corkran</u>		14. MOTHER'S MARRIED NAME <u>Mary Neighbors</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Mrs Marcella R Corkran</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Carcinoma of Liver

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-1-, 1951, to 6-27-, 1951, that I last saw the deceasedalive on 6-27-, 1951, and that death occurred at 11 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Buried 6/28/51 Oxford Oxford MdDATE REC'D BY LOCAL REG. 6/28/51 REGISTRAR'S SIGNATURE M. B. Neer FUNERAL DIRECTOR M. B. Neer ADDRESS Exton

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

13013
JUL 8 1951
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06305

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Tacket</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Tacket</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>407 August</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First) <u>Jane</u> (Middle)		(Last) <u>Elliot</u>	
4. SEX <u>Female</u>		5. COLOR OR RACE <u>White</u>		6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	
7. DATE OF BIRTH <u>Feb 26, 1880</u>		8. AGE last birthday <u>71</u> yrs.		9. DATE OF DEATH <u>June 7, 1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Housewife for Tacket from Easton Md.</u>				<u>Tacket, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>U.S.</u>		<u>William B. Greenwood</u>		<u>Margaret Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.		17. INFORMANT	
<u>No</u>		<u>No</u>		<u>Lorrie Elliot, Easton Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) apoplexy

INTERVAL BETWEEN ONSET AND DEATH

One week

Antecedent cause(s)

(b) 1st C. V. D.

6 months

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-5-, 1951, to 6-4-, 1951, that I last saw the deceased

alive on 6-4-, 1951, and that death occurred at 12:50 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

24N N. Charles Street, Baltimore

06476

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot Co</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u> TOWN <u>Easton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hosp</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Queen Anne</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne, md</u> TOWN <u>Queen Anne, md</u> STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (Type or Print) <u>Mr. Howard</u> (First) <u>Howes</u> (Middle) <u></u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>30</u> (Year) <u>1957</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>m</u>	8. DATE OF BIRTH <u>April 27, 1882</u> <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barbering - cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	9. AGE last birthday If under 1 year Months Days Hours Min. <u>69</u> yrs.
11. FATHER'S NAME <u>Mr. Nathan Howes</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Wheeler</u>	
15. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT AND ADDRESS <u>Mrs. Nellie Howes (Sister)</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of the head of the

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) pancreas(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) <u></u> (COUNTY) <u></u> (STATE) <u></u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u></u>

22. I hereby certify that I attended the deceased from 6/21, 1957, to 30 June, 1957, that I last saw the deceased alive on 30 June, 1957, and that death occurred at 1:30 pm m., from the causes and on the date stated above.

SIGNATURE Howard Howes(Degree or title) Dr. C. CokerADDRESS Queen Anne, MarylandDATE SIGNED 3 July 57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>July 3, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	LOCATION (City, town, or county) <u>Bethesda, Md</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>7/1/57</u>	REGISTRAR'S SIGNATURE <u>M. A. Neirius</u>	24. FUNERAL DIRECTOR <u>J. David Howes & Son</u>	ADDRESS <u>Bethesda, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 17 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Maryland</u> <u>Falbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> TOWN <u>Easton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>24 Port Street</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Falbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> TOWN <u>Easton</u> STREET ADDRESS (If rural, give location) <u>24 Port Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u>	(Middle) <u>C</u>	(Last) <u>Gibson</u>
5. SEX <u>m</u>	6. COLOR OR RACE <u>e</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>m</u>	8. DATE OF BIRTH <u>Aug 14, 1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>md</u>
13. FATHER'S NAME <u>William Gibson</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Elyza Gibson (wife)</u>

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Tuberculous meningitis

INTERVAL BETWEEN ONSET AND DEATH

1 wk ±

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY

INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased

alive on 19....., and that death occurred at 8:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/14/51

N.A. Neerues

Herbert M. St. Clair, Jr.

Cambridge Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A5

RECEIVED
JUN 19 1951
BUREAU V. S.

This patient
died on
the way
to Baltimore
Md.

MARYLAND STATE DEPARTMENT OF HEALTH

06307

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.290.....

1. PLACE OF DEATH- COUNTY <u>Talbot Co</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chesestown</u> STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) <u>Mr. John Hall</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>17</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Aug 29, 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Cuts</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>43</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mins.
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Mr Robert Hall</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Parks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>7</u>	
17. INFORMANT AND ADDRESS <u>Miss Bessie Hall Jones</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Hodgkin's Disease

INTERVAL BETWEEN ONSET AND DEATH

18 mos.

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐ (STATE)

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1950, to 17 June 1957, that I last saw the deceased alive on 17 June 1957, and that death occurred at 7:30 PM m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/18/57N. A. NeerLeCompte Funeral ServiceCambridge, Md. 680406

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUN 25 1951
BUREAU V. S.

06308

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>RURAL</u>	
3. NAME OF DECEASED (Type or Print) <u>LIZZIE</u> (First) <u>HARRIS</u> (Last)		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>7</u> <u>1880</u>
9. AGE last birthday <u>71</u> yrs.		10. If under 1 year Months <u>6</u> Days <u>27</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Talbot Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Wilson</u>		14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Isaac Mason</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) DCVD

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Blind & deaf

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

yearsyears

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 28, 1951, 19....., to June 28, 1951, 19....., that I last saw the deceasedalive on June 28, 1951, 19....., and that death occurred at 8 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL-CREATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

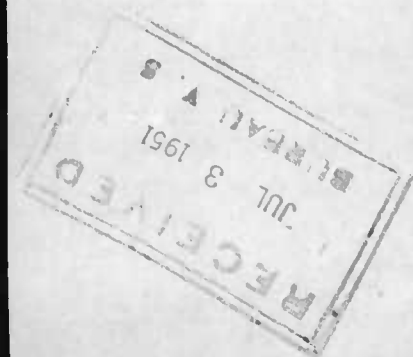
ADDRESS

Louis M. M. D. M. E.Easton Md6-28-51JUNE 28, 1951 IN TOWN CEMETERY, EASTON (RURAL) MD6/28/51 N.A. Neer MAURICE E. NEWHAM & SON EASTON, MD.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Preston, Ind.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>ENOS</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>JUNE 3 1951</u> (Month) (Day) (Year)	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Oct 28, 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>80</u> yrs. If under 1 year Months Days Hours Mins.
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John Harvey</u>		14. MOTHER'S MAIDEN NAME <u>Ann Mone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Mr Charles Payne, Jr.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Leukemia

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Coraia Raul Dience

(c) 0

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Obstruction

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5/10, 1951, to 6/3, 1951, that I last saw the deceased alive on 6/1, 1951, and that death occurred at 3:35 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 413

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

06310

1. PLACE OF DEATH-COUNTY <i>Talbot.</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED-STATE <i>Maryland.</i>		COUNTY <i>Talbot.</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Easton</i>		LENGTH OF STAY (in this place) <i>13 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Trappe</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Easton Memorial Hospital</i>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) <i>17.</i>		(First)		(Middle)		(Last)	
4. DATE OF DEATH <i>June 2 1957</i>		(Month)		(Day)		(Year)	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>30/8/97</i>	
9. AGE last birthday <i>73</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Mr John R. Hughes</i>		14. MOTHER'S MAIDEN NAME <i>Clara E. Kemp</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY No. <i>Unknown</i>	
17. INFORMANT AND ADDRESS <i>Mrs Walter Johnson Cambridge Md</i>							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <i>(a) Cerebral Vascular Accident</i>						<i>14 days</i>	
Antecedent cause(s) <i>(b) Cerebral Arteriosclerosis</i>						<i>Yrs.</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>(c) Hypertensive Cardiovascular Disease</i>						<i>Yrs.</i>	
19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/49</i> , 19....., to <i>6/2</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>6/2</i> , 19 <i>51</i> , and that death occurred at <i>11:12 p.m.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Shepard Knech Jr</i>		(Degree or title) <i>M.D.</i>		ADDRESS <i>Easton</i>		DATE SIGNED <i>6/5/57</i>	
23. BURIAL/CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>June 3/57</i>		NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		LOCATION (City, town, or county) (State) <i>Easton Md</i>	
DATE REC'D BY LOCAL REG. <i>6/3/57</i>		REGISTRAR'S SIGNATURE <i>N.A. Neer</i>		24. FEDERAL DIRECTOR <i>Manuel E. Jordan</i>		ADDRESS <i>Don</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

2 70906

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

RECEIVED
JUN 12 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06311

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>St. Michaels</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>St. Michaels</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u>	(Middle) <u>M.</u>	(Last) <u>JACKSON</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>UNKNOWN</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic & own home.</u>	9. AGE last birthday <u>About 90 yrs.</u>
13. FATHER'S NAME <u>John DRAKE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		14. MOTHER'S MAIDEN NAME <u>HANNA TURNER</u>	
16. SOCIAL SECURITY No. <u>NO</u>		17. INFORMANT AND ADDRESS <u>LAVINA MITCHELL - LAKE VILLA, CONN. 40 MRS. HAVILAND</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardiac failure

INTERVAL BETWEEN ONSET AND DEATH

One wk

442X Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic cardio-vascular-renal disease

?

131a

(c) General debility with inanition.

10 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from D.O.A., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at 9:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

William H. Marshall M.D. PO 388 ST. MICHAELS, MARYLAND 6-2-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>6/4/51</u>	<u>St. Michaels</u>	<u>St. Michaels - Talbot - Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>June 3, 51</u>	<u>Mr. Robert L. Scott</u>	<u>NORMAN D. MARSHALL St. Michaels, Md.</u>	

720826

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06312 6-14

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Born in hospital</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>Died in hospital</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Baby</u>	(Middle) <u>girl</u>	(Last) <u>Jacobs.</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>June 5, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>MD. (Memorial Hospital)</u>	12. CITIZEN OF WHAT COUNTRY? <u>same</u>
13. FATHER'S NAME <u>James Grace</u>		14. MOTHER'S MAIDEN NAME <u>Emily Jacobs</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Emily Jacobs (same)</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			12 hrs
(a) Immediate cause <u>Cardiac Anoxia</u>			
(b) Antecedent cause(s) <u>Placenta Previa (Mother)</u>			
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
SUICIDE		INJURY	
HOMICIDE			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED	
OF INJURY		While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 6-5, 1951, to 6-6, 1951, that I last saw the deceased alive on 6-6, 1951, and that death occurred at 8:15 a.m., from the causes and on the date stated above.

SIGNATURE John E. Baylutt MD ADDRESS 214 Dover St Easton MD DATE SIGNED 6/19/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/6/51</u>	<u>Cordova</u>	<u>Cordova</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6/6/51</u>	<u>M.D. Neerud</u>	<u>James</u>	<u>Cordova Md</u>	

20605199099V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

06313

1. PLACE OF DEATH- COUNTY <i>Talbot Co</i> <i>Easton</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Queen Anne</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Easton, Md</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Easton, Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Easton Memorial Hosp</i>		STREET ADDRESS (If rural, give location) <i>Easton, Md</i>	
3. NAME OF DECEASED (Type or Print) (First) <i>Doc</i> (Middle) <i>Harry</i> (Last) <i>Kemp</i>		4. DATE OF DEATH (Month) <i>June</i> (Day) <i>26</i> (Year) <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH <i>5/15/76</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE last birthday <i>75</i> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Mr Hugh Kemp</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Fleedman</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>220-03-3507</i>	
17. INFORMANT AND ADDRESS <i>Mrs Bessie Kemp</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Cardiac failure, due to myocardial infarction, due to atherosclerotic coronary thrombosis</i>			
Antecedent cause(s) (b) <i>420.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</i>			
(c) <i>94a</i>			<i>6 days</i>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>24 June</i> , 19 <i>57</i> , to <i>26 June</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>26 June</i> , 19 <i>57</i> , and that death occurred at <i>10:20 p.m.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Thurston Harrison</i>		ADDRESS <i>Easton, Maryland</i> DATE SIGNED <i>26 June 57</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i> DATE THEREOF <i>6/29/57</i> NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i> LOCATION (City, town, or county) <i>Easton</i> (State) <i>Md</i>			
DATE REC'D BY LOCAL REG. <i>6/27/57</i> REGISTRAR'S SIGNATURE <i>N.H. Newby</i>		24. FUNERAL DIRECTOR <i>M. S. Newman & Son, Easton Md</i> ADDRESS	

100105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS [A-1]

RECEIVED
JUL 3 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06314

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>		LENGTH OF STAY (In this place) <u>11 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Centreville Road</u>				STREET ADDRESS (If rural, give location) <u>Centreville Road</u>	
3. NAME OF DECEASED (Type or Print)		(First) <u>Wilson</u>	(Middle) <u>Thomas</u>	(Last) <u>Milligan</u>	4. DATE OF DEATH (Month) <u>6</u> (Day) <u>23</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 6, 1915</u>	9. AGE last birthday <u>35</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee Peoples Ice Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ice</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Maryland</u>	
13. FATHER'S NAME <u>Frank Milligan</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>217-16-9590</u>		17. INFORMANT <u>Mrs. Lena M. Milligan, Easton, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Suicide - G.S.W. head

INTERVAL BETWEEN ONSET AND DEATH

Instant

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 6 23 51 9P m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?
G.S.W. - head

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Louis Whearty

IND JUNE

Easton Md

6-24-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/24/51

N.A. Neurus

J. J. Frampton and Son, Federalsburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

T

1100419

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

06315

1. PLACE OF DEATH COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EASTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EASTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>ALVERTA</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>about 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CANNING House</u>	9. AGE last birthday <u>57</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Talbot County - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William FLAMER</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>220-03-5313</u>	
17. INFORMANT AND ADDRESS <u>PAUL MONROE 504 Asbury PL.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Uremia, Hypertensive Heart Disease

Antecedent cause(s) (b) Arteriosclerotic Nephritis, Atheromatosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE <u>No</u> (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY // // // //	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? // // // //

22. I hereby certify that I attended the deceased from Jan 15, 1951, to June 17, 1951, that I last saw the deceased

alive on June 15, 1951, and that death occurred at 3 A.M., from the causes and on the date stated above.

SIGNATURE Philip B. Lewis (Degree or title) M.D. ADDRESS St. Michaels, Md DATE SIGNED 6.18.51

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>6/19/51</u>	NAME OF CEMETERY OR CREMATORY <u>Chapel</u>	LOCATION (City, town, or county) (State) <u>Chapel, Maryland</u>
DATE REC'D BY LOCAL REG. <u>6/19/51</u>	REGISTRAR'S SIGNATURE <u>N.H. Neer</u>	24. FUNERAL DIRECTOR <u>NORMAN D. MARSHALL</u>	ADDRESS <u>ST. MICHAELS, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415-1

RECEIVED
JUN 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06316

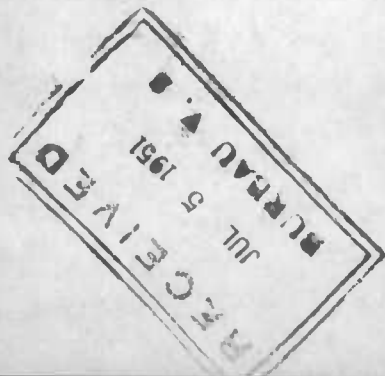
Reg. Dist. No. 294

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>McDANIEL</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>McDANIEL</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First) <u>FRANKLIN</u>		(Middle) <u>DONNELL</u>		(Last) <u>MURRAY</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>25</u> (Year) <u>1951</u>	
8. DATE OF BIRTH <u>2/26/39</u>		9. AGE last birthday <u>12</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>McDANIEL Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>WM JOS HENRY MURRAY</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA SMITH HORSEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>BERTHA SMITH</u>		18. MEDICAL CERTIFICATION <u>11 Ridge Drive GREAT MECK, LONG</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
Immediate cause <u>929.8 Accidental drowning</u>							
Antecedent cause(s) <u>183 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>accident</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>HARRIS CK nr. McDaniel Tal.</u>		(CITY OR TOWN) (COUNTY) (STATE) <u>Tal. Md</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6 25 51 a.m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>acc. drowning while swimming</u>			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... SIGNATURE <u>Louis J. White Md DME Eastern Md</u> ADDRESS <u>6-76-51</u>							
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>6/27/51</u>		NAME OF CEMETERY OR CREMATORY <u>CLAIBORNE, Md.</u>		LOCATION (City, town, or county) (State) <u>CLAIBORNE - Talbot - Md.</u>	
DATE REC'D BY LOCAL REG. <u>June 27-51</u>		REGISTRAR'S SIGNATURE <u>G. Wesley Sewell</u>		24. FUNERAL DIRECTOR <u>NORMAN D. MARSHALL</u>		ADDRESS <u>St. MICHAELS Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 298

1. PLACE OF DEATH- COUNTY <u>Talbot Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Heber</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton, Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Alford, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Mr. Herbert Parrott</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>26</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>7-14-71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>79</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OR WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Parrott</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Gannon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mr. Hughlett Parrott</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Arteriosclerosis, generalized2 yrs?

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐ (STATE)

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 6-14, 1951, to 6-26, 1957, that I last saw the deceased alive on 6-26, 1957, and that death occurred at 7:59 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>burial</u>	<u>6/29/57</u>	<u>Spring Hill</u>	<u>Easton, Md</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6/27/57</u>	<u>H. A. Rehrer</u>	<u>Rayback</u>	<u>Easton, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1

RECEIVED
JUL 3 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

06318

1. PLACE OF DEATH- COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington St. Ext.</u>		STREET ADDRESS (If rural, give location) <u>Washington St. Ext.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>ANNIE</u> (Middle) <u>EMILY</u> (Last) <u>Patchett</u>		4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>Nov. 22, 1874</u>
9. AGE last birthday <u>76</u> yrs. Months <u>6</u> Days <u>29</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>CAROLINE Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL JAMES</u>		14. MOTHER'S MAIDEN NAME <u>MARY Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Emma Upton 153 Henry St. BROOKLYN N.Y.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Carcinoma of Liver</u>		<u>6 months</u>
156.1 Antecedent cause(s) (b) <u>giving rise to the above cause stating the underlying cause last</u>		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1951, to 6/22/51, that I last saw the deceased alive on 6/21/51, 1951, and that death occurred at 8 P.M. m., from the causes and on the date stated above.

SIGNATURE <u>W.D. Cox</u>	(Degree or title)	ADDRESS <u>Easton Md</u>	DATE SIGNED <u>6/22/51</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>6/23/51</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	LOCATION (City, town, or county) (State) <u>Easton, Md</u>
DATE REC'D BY LOCAL REG. <u>6/22/51</u>	REGISTRAR'S SIGNATURE <u>N.D. Neeress</u>	24. FUNERAL DIRECTOR <u>MAURICE E. NEWNAM & SON</u>	ADDRESS <u>Easton, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH - COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MARYLAND</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>Rural</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>PEARL</u> (Middle) (Last) <u>PINKNEY</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>?</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>50+</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Will Brown</u>		14. MOTHER'S MAIDEN NAME <u>Sally Massey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Ellie Pinkney</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

nephroderosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

arteriosclerosis, generalized

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/4, 1951, to 6/18/51, 1951; that I last saw the deceasedalive on 6/18/51, 1951; and that death occurred at 5:38 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JUN 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

06320

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>CAROLINE</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>CHARLES</u>	(Middle) <u>A.</u>	(Last) <u>Rampmeyer</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>New York City</u>
13. FATHER'S NAME <u>August Rampmeyer</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Weber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Memorial Hospital - Easton Md</u>

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Coronary Embolus

137a Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio sclerosis
Hypertrophied prostate.11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.(c) Retropubic prostatectomy

19a. DATE OF OPERATION

June 12, 1951

19b. MAJOR FINDINGS OF OPERATION

Hard nodular
fixed growth in prostate

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 4, 1951, to June 14, 1951, that I last saw the deceased alive on June 14, 1951, and that death occurred at 3:40 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

John F. Schneider, M.D. Easton, Maryland June 15, 1951

Bureau 6/17/51 Ridgely Ridgely, Md.

6/15/51 N.H. Neer R.B. Rawlings Dr. B. Rawlings

500416 Md.

RECEIVED

JUL 1 1951

BUREAU V. S.

Reg. Dist. No. 294

1. PLACE OF DEATH. COUNTY <u>TAIBOT</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>MARYLAND</u> COUNTY <u>TAIBOT</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>WITTMAN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BOZMAN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>RURAL</u>	
3. NAME OF DECEASED (First) <u>ROBERT</u> (Middle) <u>T.</u> (Last) <u>SCOTT</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG 1 1893</u>
9. AGE last birthday <u>57</u> yrs. If under 1 year Months Days Hours Min.		10. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>MURRY SCOTT</u>		14. MOTHER'S MAIDEN NAME <u>LUCY ANN GAINES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Robert T. Scott, Wittman, Ind.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH		
Immediate cause		(a) <u>Cancer Prostate gland</u>					5 yrs.		
Antecedent cause(s) <small>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</small>		(b)							
		(c)							
II. OTHER SIGNIFICANT CONDITIONS <small>Conditions contributing to the death but not related to the disease or condition causing death.</small>									
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19<u>85</u>, to <u>June 19, 87</u>, that I last saw the deceased alive on <u>June 10, 87</u>, and that death occurred at <u>1039</u> m., from the causes and on the date stated above.									
SIGNATURE <u>Dr. Wm. R. S. Jones</u>				(Degree or title) <u>M.D.</u>		ADDRESS <u>Newman & Harrison, St. Michaels</u>		DATE SIGNED <u>June 19, 87</u>	
23. BURIAL, CREMATION REMOVAL		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>June 20, 1987</u>		<u>Bozman Cemetery</u>		<u>Bozman,</u>		<u>MD</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS			
<u>June 19-87</u>		<u>G. Wesley Sewell</u>		<u>Newman & Harrison</u>		<u>St. Michaels</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06322 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fishing Creek</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>(none)</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>CLARA</u>	(Middle) <u>TRAVERS</u>	(Last) <u>SIMMONS</u>
4. DATE OF DEATH	(Month) <u>JUNE</u>	(Day) <u>12</u>	(Year) <u>51</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-2-1885</u>
9. AGE last birthday <u>66 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Travers</u>		14. MOTHER'S MAIDEN NAME <u>Ida Bell Dorr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Edward Simmons- Fishing Creek, Maryland</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocarditis

Antecedent cause(s)

(b) Rheumatic valv

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 months

40 yr.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July, 1950, to June 12, 1951, that I last saw the deceased alive on June 12, 1951, and that death occurred at 5:55 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-14-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Hoosier Memorial Cemetery-Fishing Creek, Md.</u>	LOCATION (City, town, or county) <u>Fishing Creek, Md.</u>	(State) <u>Md.</u>
DATE REC'D. BY LOCAL REG. <u>6/13/51</u>	REGISTRAR'S SIGNATURE <u>M. V. Palmer M.D.</u>	24. FUNERAL DIRECTOR <u>LeCompte Funeral Service,</u>	ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A3

RECEIVED
JUN 19 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

06323

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Quail Trappe</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Quail Trappe</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Larance</u> (First) <u>Alexander</u> (Middle) <u>Skippier</u> (Last)		4. DATE OF DEATH <u>June</u> (Month) <u>28</u> (Day) <u>1951</u> (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 19, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	9. AGE last birthday <u>56</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Talbot County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Alexander Skippier</u>		14. MOTHER'S MAIDEN NAME <u>Annie Rebecca Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>217-30-8767</u>	
17. INFORMANT <u>Mrs C. A. Skippier</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
Immediate cause (a) <u>Coronary occlusion</u>	INTERVAL BETWEEN ONSET AND DEATH <u>Immed</u>
Antecedent cause(s) (b) <u>420.1 94a</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE <u>Louis M. Mott, MD</u>	ADDRESS <u>One Easton Rd</u>	DATE SIGNED <u>6-28-51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>July 3, 51</u>	NAME OF CEMETERY OR CREMATORY <u>Quail Trappe</u>
LOCATION (City, town, or county) <u>MD</u>	(State)	
DATE REC'D BY LOCAL REG. <u>6/29/51</u>	REGISTRAR'S SIGNATURE <u>N. L. Neerius</u>	24. FUNERAL DIRECTOR <u>Quail Trappe</u>
ADDRESS <u>Quail Trappe</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 6 1961
BUREAU A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>122 S. Harrison Street</u>	
3. NAME OF DECEASED (Type or Print) <u>hulu</u> (First) <u>m.</u> (Middle) <u>Smith</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>None</u>	8. DATE OF BIRTH <u>1875 May 28</u> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Mr. William E. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Jump</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		17. INFORMANT AND ADDRESS <u>Mrs. Carrie Smith (Saneadum) as wife</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Paralysis agitans

Antecedent cause(s)

(b) Arteriosclerosis, generalized

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3/1, 1949, to 6-1-, 1951, that I last saw the deceasedalive on 6-1-, 1951, and that death occurred at 10:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>6/3/51</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	LOCATION (City, town, or county) <u>Easton</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>6/2/51</u>	REGISTRAR'S SIGNATURE <u>N. H. Neer</u>	4. FUNERAL DIRECTOR <u>R. Ellis Clark</u>	ADDRESS <u>Easton MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 115

RECEIVED
JUN 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06325

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oxford, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Laurel Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Robert</u> (Middle) <u>B.</u> (Last) <u>Taylor</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>27</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>April 5, 1918</u>
9. AGE last birthday <u>33</u> ym.		10. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>	
11. BIRTHPLACE (State or foreign country) <u>Preston, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harry D. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Glady's Reeder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>U.S. Army</u>		16. SOCIAL SECURITY NO. <u>216-03-7419</u>	
17. INFORMANT <u>Harry Taylor</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Accidental Drowning

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>Accident</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>road</u>	(CITY OR TOWN) <u>Oxford</u> (COUNTY) <u>Talbot</u> (STATE) <u>Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6</u> <u>28</u> <u>51</u> <u>9:30 PM</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>fell from boat - couldn't swim</u>

22. I hereby certify that I attended the deceased from 19..... to 19....., that I last saw the deceased

alive on 19....., and that death occurred at m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

490846

RECEIVED
JUL 3 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06326

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesler</u>	
TOWN <u>Easton</u>		TOWN <u>Chesler</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Eugene</u> (First) <u>Earl</u> (Middle) <u>Thompson</u> (Last)		4. DATE OF DEATH <u>June</u> (Month) <u>9</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 31, 1901</u>
9. AGE last birthday <u>50</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eugene Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Marion Lawrence</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Adelaide Thompson (Same)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardiac failure, see coronary

Antecedent cause(s)

(b) Thrombosis
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(c) Alcoholic cirrhosis

INTERVAL BETWEEN ONSET AND DEATH

4 days3 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Not While	HOW DID INJURY OCCUR?		
OF INJURY	m. Work <input type="checkbox"/> At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from June 9, 1951, to June 9, 1951, that I last saw the deceased alive on June 9, 1951, and that death occurred at 11:25 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	<u>6/13/51</u>	<u>Stevensville</u>	<u>Stevensville</u>	<u>MD.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>6/10/51</u>	<u>N.H. Neerue</u>	<u>Edna E. Lane Church Hall</u>		

510246

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 19 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06327

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY Talbot		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Colorado COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN nr Trappe		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Denver	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)	
Peter Schuyler Van Schaack		6 18 1951	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
male	white		May 10, 1924
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday
Lt JG US Navy			27 yrs.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Denver, Colo.		U S A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Robert C. VanSchaack		Coris C. Carnahan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Yes		unknown	
17. INFORMANT			
Lt. JG, Dodge, U. S. N.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Suicide-carbon monoxide poisoning**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY **6 18 '51**INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

hose from exhaust led into car

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Removal - Under 24 hrs. by U. S. Naval Ambulance Annapolis

6/20/51 **N. H. Heer** **John D. Williams** **Easton, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 25 1991
BUREAU V. S.

RECEIVED
JUN 25 1991
BUREAU V. S.